Practitioner Utilization: 2003-2004

Trends within Privately Insured Patients

Maryland Health Care Commission
April 20, 2006

Report Organization

1. Introduction - Use of practitioner services for under-age-65, privately-insured MD residents.

2. Trends in Payment for Practitioner Services

New Item

3. Utilization and Intensity of Practitioner Services in Maryland

Expanded

4. Cost Sharing For Practitioner Services

Changes in Patients and Expenditures 2003-2004

- The number of privately insured patients declined.
  - Number treated by HMOs grew and those treated by non-HMOs declined.
  - Consistent with recent coverage reports.
- Spending growth per capita appears to be slowing.
  - Growth was driven by 1-2% increases in fees.
  - 1% increase in resource use per patient.

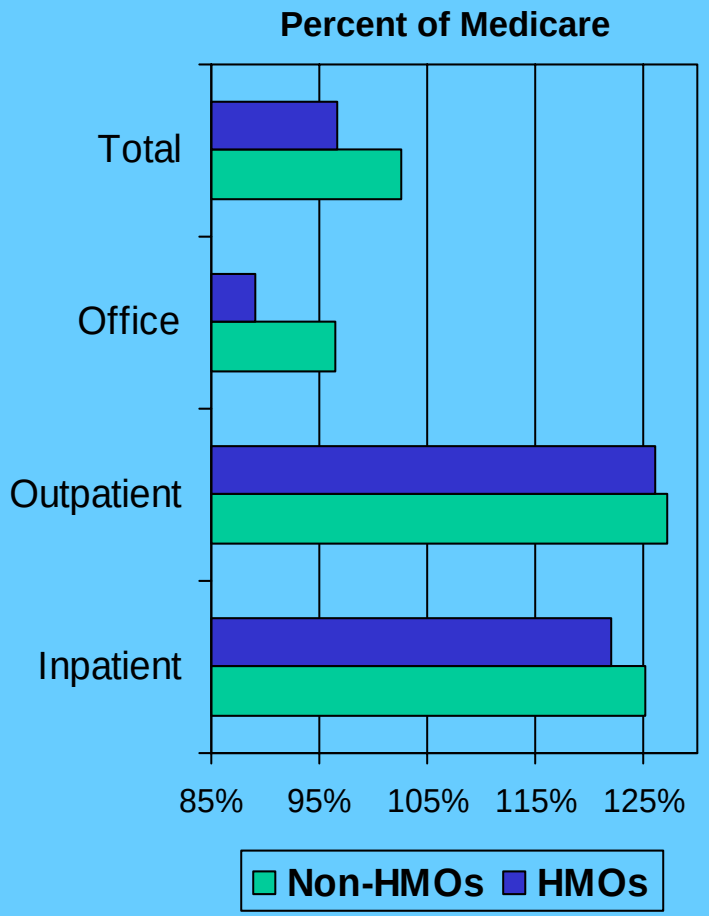
What Do We Know About the Distribution of Services?

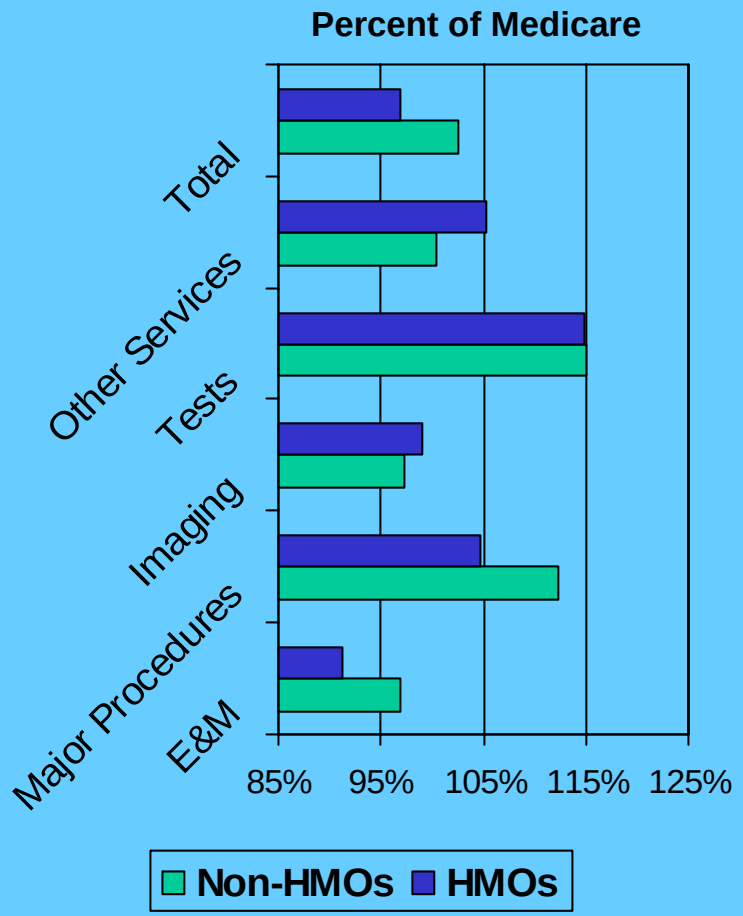
- Routine visits and consultations account for nearly half of all care, major & minor procedures account for one-quarter.
- About three-fourths of services are provided in non-hospital settings.
- Large payers reimburse over three quarters of all non-HMO services and just over two-thirds of care under HMOs.
- Most services are provided by participating providers.

Private Sector Fees – Comparisons with Medicare

- In the aggregate, the average private non-HMO fee is 3% above Medicare, and the average HMO-FFS fee is 3% below Medicare.
- Input costs in Maryland are generally above national average.
- In the U.S., the average private fee is about 123% of Medicare.
- Differences in fee levels between large payers and other payers in Maryland market.

Private Fees Relative to Medicare Vary by Place of Service and Type of Service

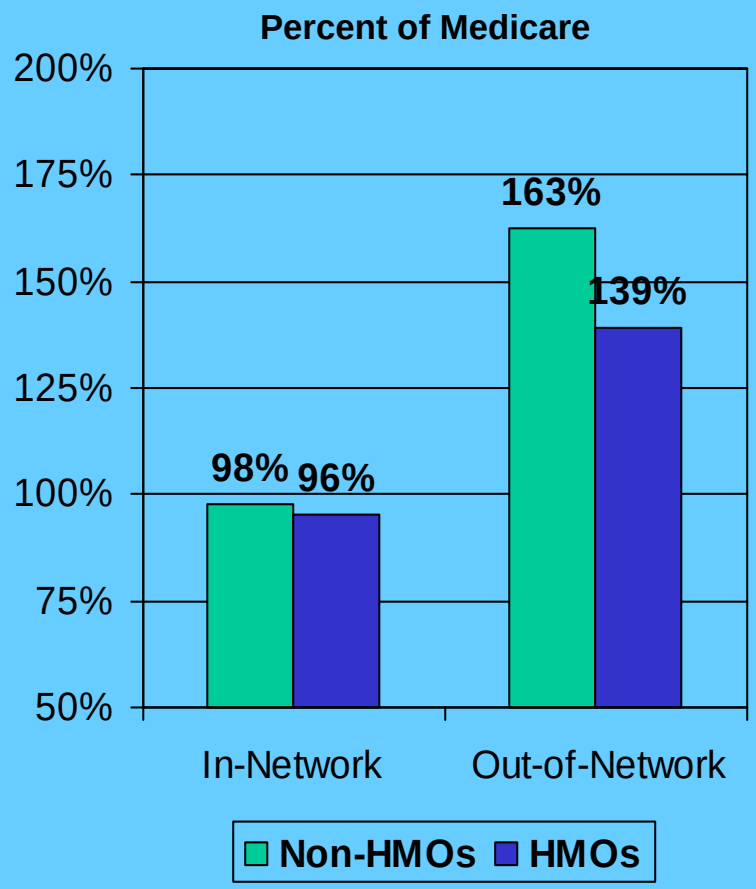




On average Non-HMOs paid $40 per RVU, HMOs $38 per RVU.

Does not include bonuses paid by plans to participating providers.

Differences Between Participating and Non-Participating Fees Fuel Policy Debate

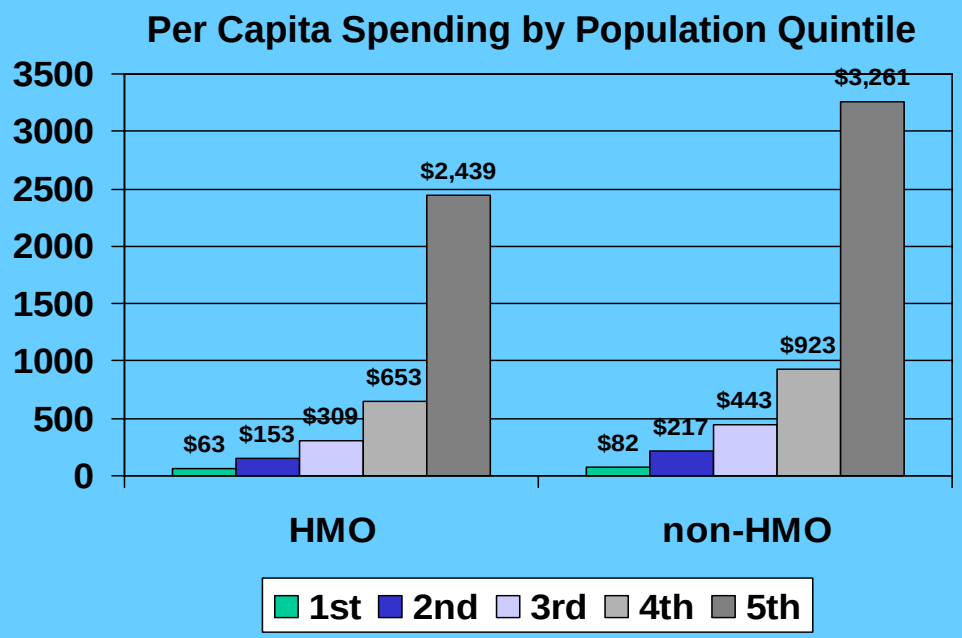


- MHCC estimates that non-participating providers account for 6% of payments in HMOs and 11% in non-HMOs.
- Use of non-participating providers is significant in hospital settings. About 30% of emergency medicine payment is to non-participating doctors.
- Current law sets minimum payment for non-participating providers in HMOs.
- Non-participating providers for non-HMOs bill UCR.

Does not include bonuses paid by plans to participating providers

Small Share of Patients Account for Majority of Spending

- Patients in the top quintile of users account for 66% of spending.
- Per capita spending in the top quintile is 40 times that in the lowest quintile.
- Pattern is consistent for HMOs and non-HMOs.
- Top quintile's share is less dramatic than for all health care services.
  - Hospital expenditures drive spending for high cost users.



Patient Share of Spending

- Small increase in out-of-pocket share from 2003 to 2004.
- Patients' share lower in HMOs (12%) than non-HMOs (20%)
  - HMOs offer fixed co-payments, not coinsurance, in lieu of choice.
- Lowest patient share in public employee plans, highest in individual market.
- CSHBP cost-sharing higher than other private products, but lower than individual products. Overall cost-sharing was stable to just slightly higher 2003-2004 (19%-20%).
- Cost sharing declines as level of spending increases.

Conclusions

- Modest fee increase first reported in 2002 continued in 2004. Overall fees are about 5% higher than 1999. Input prices increased 19%.
- Physician fees track with average Medicare fees. Difference between HMO and non-HMO average payments is small.
- Significant variance in fees by type of service and place of service.
- Differences between in-network and out-of-network rates are dramatic.
- CSHBP patient shares of costs are above, but relatively close to other group products.

Price Transparency

- **Work with plans and providers to promote consumerism.**
  - Payers are moving toward high performance networks -- providers whose prices are lower or who are deemed to be higher quality or more efficient.
  - Goal is to combine cost, efficiency and quality information.
  - Managed care remains a powerful force in negotiating discounts for enrollees.

- **Need to be realistic and practical about MHCC data.**
  - Existing information gap is wide.
  - For insured, insurers hold more extensive information.
  - No specific physician identification in MHCC data.

Price Transparency (continued)

- **Pricing information may be helpful to uninsured.**
  - A significant gap exists between participating fees and billed fees (non-participating).
  - Focus on bundled services, office visits, diagnostic tests, some ambulatory procedures.
  - Limit to common specialties.